# Complete Summary

## GUIDELINE TITLE

Recommendations to reduce injuries to motor vehicle occupants: increasing child safety seat use, increasing safety belt use, and reducing alcohol-impaired driving.

## BIBLIOGRAPHIC SOURCE(S)

Recommendations to reduce injuries to motor vehicle occupants: increasing child safety seat use, increasing safety belt use, and reducing alcohol-impaired driving. Am J Prev Med 2001 Nov;21(4 Suppl 1):16-22. [35 references]

## COMPLETE SUMMARY CONTENT

SCOPE
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## SCOPE

### DISEASE/CONDITION(S)

Injuries to motor vehicle occupants

### GUIDELINE CATEGORY

Counseling
Prevention

### CLINICAL SPECIALTY

Family Practice
Internal Medicine
Pediatrics
Preventive Medicine

### INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Health Plans
Nurses
Physician Assistants
Physicians
Public Health Departments
Students

## GUIDELINE OBJECTIVE(S)

To provide recommendations to increase the use of child safety seats, to increase the use of safety belts, and to reduce alcohol-impaired driving

## TARGET POPULATION

General population in the United States

## INTERVENTIONS AND PRACTICES CONSIDERED

### Increasing child safety seat use:

1. Child safety seat laws
2. Community-wide information and enhanced enforcement campaigns
3. Distribution and education programs
4. Incentive and education programs
5. Education-only programs

### Increasing safety belt use

1. Safety belt laws
2. Primary enforcement safety belt laws
3. Enhanced enforcement programs

### Reducing alcohol-impaired driving

1. 0.08 blood alcohol concentration (BAC) laws
2. Lower blood alcohol concentration laws for young or inexperienced drivers
3. Maintaining the minimum legal drinking age at 21 years
4. Sobriety checkpoints
5. Intervention training programs for servers of alcohol beverages

## MAJOR OUTCOMES CONSIDERED

### Increasing child safety seat use

- Possession of child safety seats
- Correct use of child safety seats
- Fatal and nonfatal injuries

### Increasing safety belt use

- Safety belt use (observed, police reported, or self-reported)
- Fatal and nonfatal injuries

### Reducing alcohol-impaired driving

- Drinking and driving
- Alcohol-related crashes
- Fatal and nonfatal injuries

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The reviews of interventions to reduce motor vehicle occupant injury reflect systematic searches of multiple databases as well as reviews of reference lists and consultations with experts in the field. The team searched six computerized databases (MEDLINE, Embase, PsycLIT, Sociological Abstracts, EI Compendex, and Transportation Research Information Services [TRIS]), which yielded 10,958 titles and abstracts for screening. Studies were eligible for inclusion if:

- They were published from the originating date of the database through June 2000 (March 1998 for child safety seat interventions).
- They involved primary studies, not guidelines or reviews.
- They were published in English.
- They were relevant to the interventions selected for review.
- The evaluation included a comparison to an unexposed or less-exposed population.
- The evaluation measured outcomes defined by the analytic framework for the intervention.

After screening titles and abstracts, 3653 papers were collected for further screening and 277 of these papers ultimately met the inclusion criteria.

Individual studies were grouped together on the basis of the similarity of the interventions being evaluated and were analyzed as a group. Some studies provided evidence for more than one intervention. In those cases, the studies were reviewed for each applicable intervention. Interventions and outcome measures were classified according to definitions developed as part of the review process. The classification and nomenclature used in the systematic reviews sometimes differs from that used in the original studies.

### NUMBER OF SOURCE DOCUMENTS

- 277 papers met inclusion criteria, of which 102 were excluded on the basis of study limitations
- 175 papers were considered qualifying studies

## METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

## RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Studies are categorized as having good, fair, or limited quality of execution based on the number of limitations (i.e., threats to validity) noted. Studies with limited quality of execution were not included in the summary effect of the intervention.

Good: 0 to 1 study limitations

Fair: 2 to 4 study limitations

Limited: 5 or more study limitations

Studies were evaluated for limitations in execution with respect to the following six categories (a total of 9 limitations are possible):

- Study and intervention descriptions
- Sampling
- Exposure and outcome measurement
- Data analysis
- Interpretation of results (including follow-up, bias, and confounding)
- Other

In addition, the body of evidence of effectiveness is characterized as strong, sufficient, or insufficient based on the number of available studies, the suitability of their design and quality of execution, and the size and consistency of reported effects.

## METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

## DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

For each intervention reviewed, the team developed an analytic framework indicating possible causal links between the intervention under study and predefined outcomes of interest. To make recommendations, the Task Force on Community Preventive Services required that studies show increases in use of child safety seats or safety belts, decreases in alcohol-impaired driving, or decreases in motor-vehicle crashes or crash-related injuries. Improvements in behavioral outcomes (i.e., use of child safety seats, use of safety belts, and decreases in alcohol-impaired driving) are acceptable because:

- Child safety seats are 55% to 70% effective in preventing deaths.
- Safety belts are 45% to 60% effective in reducing deaths and 50% to 65% effective in reducing moderate-to-critical injuries.
- The risk for fatal crash involvement increases as blood alcohol levels increase.

Each study that met the inclusion criteria was evaluated using a standardized abstraction form and assessed for suitability of the study design and threats to validity. On the basis of the number of threats to validity, studies were characterized as having good, fair, or limited execution. Results on each outcome of interest were obtained from each study that met the minimum quality criteria. For studies that reported multiple measures of a given outcome, the "best" measure with respect to validity and stability was chosen according to consistently applied rules. Measures that were adjusted for the effects of potential confounders were used in preference to crude effect measures. For studies in which such adjusted results were not provided, net effects were derived when possible by calculating the difference between the changes observed in the intervention and comparison groups. A median was calculated as a summary effect measure for each outcome of interest. For bodies of evidence consisting of seven or more studies, an interquartile range is presented as an index of variability; otherwise, a simple range is reported.

The strength of the body of evidence of effectiveness was characterized as strong, sufficient, or insufficient on the basis of the number of available studies, the suitability of study designs for evaluating effectiveness, the quality of execution of the studies, the consistency of the results, and the effect size.

## METHODS USED TO FORMULATE THE RECOMMENDATIONS

Other

## DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Task Force recommendations are based primarily on the effectiveness of interventions as determined by the systematic literature review process. In making recommendations, the Task Force balances information about the effectiveness of an intervention with information about other potential benefits and potential harms. To determine how widely a recommendation should apply, the Task Force also considers the applicability of the intervention in various settings and populations. Finally, the Task Force reviews economic analyses of those interventions found to be effective and summarizes applicable barriers to intervention implementation. Economic information is provided to assist the reader with decision making but generally does not affect the Task Force´s recommendation.

## RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

In general, strength of evidence of effectiveness corresponds directly to strength of recommendations. Recommendations are rated as:

- Strongly Recommended (supported by strong evidence)

- Recommended (supported by sufficient evidence)
- Insufficient evidence to determine effectiveness

### COST ANALYSIS

For all interventions that are recommended or strongly recommended by the Task Force on Community Preventive Services, the team conducted systematic reviews of the evidence of economic efficiency. Where available, the reviews are provided to help decision-makers choose among recommended interventions. Complete evidence tables that summarize the body of the evidence on the economic efficiency of the interventions are available at the Community Guide Web site.

### METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

### DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Proposed recommendations are presented to the Task Force on Community Preventive Services, and a majority is needed to approve.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

The Task Force on Community Preventive Services evaluated the evidence of effectiveness of 13 selected interventions to address three strategies for reducing injuries to motor vehicle occupants (see Table 2 titled "Recommendations of the Task Force on Community Preventive Services for Population-based Interventions to Reduce Injuries to Motor Vehicle Occupants" in the original guideline document): (1) increasing the use of child safety seats, (2) increasing the use of safety belts, and (3) reducing alcohol-impaired driving. Evaluations of additional interventions are still in progress.

The relationship between the strength of evidence of effectiveness and the strength of the recommendation is defined at the end of the "Major Recommendations" field.

#### Interventions to Increase the Use of Child Safety Seats

Child safety seats can be extremely effective. When correctly installed and used, they reduce the risk of death by 70% for infants and by 47% to 54% for toddlers (aged 1 to 4 years) and reduce the need for hospitalization by 69% for children aged 4 years and younger. This section describes the Task Force on Community Preventive Services´ recommendations regarding five interventions designed to increase the use of child safety seats.

Child Safety Seat Laws: Strongly Recommended.

Child safety seat laws require children traveling in motor vehicles to be restrained in federally approved child restraint devices (e.g., infant or child safety seats) appropriate for the child´s age and size. The state laws, which vary widely, also specify the children to whom the law applies by age, height, weight, or a combination of these factors. Child safety seat laws are strongly recommended based on their effectiveness in reducing fatal and nonfatal injuries and increasing child safety seat use throughout the United States. No harms or other potential benefits were reported and no qualifying economic information was identified from the literature.

Community-wide Information and Enhanced Enforcement Campaigns: Recommended.

Community-wide information and enhanced enforcement campaigns seek to promote use of safety seats through the use of mass media, mailings, child safety seat displays in public sites, and special enforcement strategies such as checkpoints, dedicated law enforcement officials, or alternative penalties. These campaigns target their information and activities to an entire community, usually geographic in nature. Community-wide information and enhanced enforcement campaigns are recommended on the basis that they increase child safety seat use in a variety of populations and settings. No harms or other potential benefits were reported and no qualifying economic information was identified from the literature.

Distribution and Education Programs: Strongly Recommended.

Through distribution and education programs, approved child safety seats are given, lent, or rented at low cost to parents. All programs also include educational components of varying intensities. These programs target parents and other caregivers who might need assistance in acquiring a safety seat because of financial hardship or poor understanding of the importance of using child safety seats.

Distribution and education programs are strongly recommended on the basis that they increase child safety seat use when implemented (1) in a range of settings; (2) in a variety of population subgroups; and (3) as loan, rental, or giveaway programs. In addition, one study indicated a reduction in injury insurance claims among a population provided with safety seats by an automobile insurance company. No harms or other potential benefits were reported and no qualifying economic information was identified from the literature.

An important implementation issue regarding distribution and education programs has arisen since the studies in the review for the guideline were conducted. Because the integrity of child safety seats can be compromised in a crash, seats returned to a distribution and education program should not be lent to others because there can be no guarantee that they were not involved in a crash. Therefore, when implementing child safety seat distribution and education programs, only new, unused seats should be provided to all recipients.

Incentive and Education Programs: Recommended.

Incentive and education programs (1) provide children and parents with rewards and opportunities for rewards for the purchase and correct use of child safety seats, and (2) include educational components of varying intensities. Incentive and education programs are recommended based on their effectiveness in increasing child safety seat use in a variety of populations and settings and using various reward systems. No harms or other potential benefits were reported and no qualifying economic information was identified from the literature.

Education Programs: Insufficient Evidence.

Education programs provide information and teach skills to parents, children, or professional groups about the use of child safety seats. Information provides the basic foundation for moving people toward behavior change and can enhance skills, thus enabling behavior change. Providing information alone is rarely sufficient for sustained behavior change, but it is a central and necessary component of other interventions, such as community campaigns, distribution programs, and incentive programs.

The Task Force on Community Preventive Services identified three qualifying studies that evaluated the effect of perinatal safety seat education programs on parents´ later use of the seats for their children, one qualifying study evaluating the effect of a preschool education program on children´s safety seat use, and two qualifying studies evaluating the effect of professional education on provider and system performance in health care systems and law enforcement, respectively. Therefore, on the basis of the (1) small number of available studies, and (2) variability in the interventions evaluated, insufficient evidence exists to determine the effectiveness of education programs alone in increasing child safety seat use.

## Interventions to Increase the Use of Safety Belts

Safety belt use is estimated to have saved 123,000 lives between 1975 and 1999. If all motor vehicle occupants consistently wore safety belts, it is estimated that an additional 9,553 deaths would have been prevented in 1999 alone. Lap and shoulder safety belts are the single most effective means for occupants to reduce the risk of death and serious injury in a crash. They have been shown to reduce deaths by 45% to 60% and serious injury to the head, chest, and extremities by 50% to 83%. Overall safety belt use in the United States is estimated to be 71%. This section reports the Task Force on Community Preventive Services´ recommendations for three interventions to increase the use of safety belts.

Safety Belt Laws: Strongly Recommended.

Safety belt laws require the use of safety belts by motor vehicle occupants. Specific requirements (e.g., age, seating position, fines, exceptions) vary by state. Safety belt laws are strongly recommended based on their effectiveness in increasing safety belt use and reducing fatal and nonfatal injuries among adolescents and adults. Several studies indicated the additional benefit that laws requiring adult safety belt use also increase safety belt use by children. A potential harm of safety belt laws can be found in the theory that safety belt use will lead to other unsafe driving behaviors, thus neutralizing any beneficial effect that their use might confer. No studies reviewed, however, have shown an

association between safety belt laws and increases in unsafe driving behaviors. No qualifying economic information was identified from the literature.

Primary Enforcement Safety Belt Laws: Strongly Recommended.

Primary enforcement safety belt laws allow a police officer to stop a vehicle solely for an observed belt law violation. The Task Force on Community Preventive Services strongly recommends these laws over secondary enforcement laws, which allow a police officer to issue a belt law citation only if the vehicle has been stopped for another violation. The strong recommendation is based on the superior effectiveness of primary enforcement safety belt laws in increasing safety belt use and reducing fatal injuries compared with secondary enforcement safety belt laws in the United States. Potential harms and other positive effects considered are similar to those for safety belt laws in general. In addition, although differential enforcement based on race or ethnicity has been reported as a concern, studies that looked for evidence of such differential enforcement found none. No qualifying economic information was identified from the literature.

Enhanced Enforcement Programs: Strongly Recommended.

Enhanced enforcement programs provide increased rather than routine enforcement of safety belt laws at specific locations and times. These programs always include a publicity component. Enhanced enforcement programs are strongly recommended based on their effectiveness in increasing safety belt use and reducing fatal and nonfatal injuries in a wide range of settings and among various populations. One program reported increased corollary arrests as an additional benefit of an enhanced enforcement program. No harms were reported and no qualifying economic information was identified from the literature.

## Interventions to Reduce Alcohol-Impaired Driving

Alcohol-related motor vehicle crashes (i.e., those in which the driver had a blood alcohol concentration of at least 0.01 g/dL) resulted in 16,068 deaths and more than 300,000 injuries in 2000. This section reports on the Task Force on Community Preventive Services´ recommendations regarding five interventions to reduce alcohol-impaired driving.

0.08% Blood Alcohol Concentration Laws: Strongly Recommended.

These laws establish the illegal blood alcohol concentration (BAC) of 0.08 g/dL for drivers aged 21 years and older (lower blood alcohol levels are established for drivers 20 years old and younger). The 0.08% blood alcohol concentration laws are strongly recommended based on their effectiveness in reducing alcohol-related crash fatalities in the United States. No harms or other potential benefits were reported and no qualifying economic information was identified from the literature.

Laws That Establish a Lower Blood Alcohol Concentration Level for Young and Inexperienced Drivers: Recommended.

These laws establish a lower blood alcohol concentration level for young or inexperienced drivers than for older or more experienced drivers, making it illegal for the persons targeted by the law to drive with a blood alcohol concentration level above the established limit. In the United States, the limit is 0.02% or lower, and these laws apply to all persons under the age of 21 years (the minimum legal drinking age [MLDA] in all states). In other countries, these laws apply to either newly licensed drivers or newly licensed drivers under a specified age. The Task Force on Community Preventive Services recommends laws establishing a lower legal blood alcohol concentration for young or inexperienced drivers based on their effectiveness in reducing alcohol-related crashes in the United States and Australia. A potential harmful effect of these laws is that young drivers whose blood alcohol concentration levels exceed the legal limit for adult drivers (0.08 g/dL or 0.10 g/dL) may receive "zero tolerance" citations instead of being arrested for the more serious offense of driving under the influence of alcohol. One study reported an estimated benefit-to-cost ratio of $11 per dollar invested for lower legal blood alcohol concentration limits for young drivers.

Maintaining the Minimum Legal Drinking Age at 21 Years: Strongly Recommended.

Minimum legal drinking age laws specify an age below which the purchase and consumption of alcoholic beverages are not permitted. This review examined the effect of raising or lowering the minimum legal drinking age. All states currently have a minimum legal drinking age of 21 years. Maintaining or implementing the minimum legal drinking age at 21 years rather than at a younger age is strongly recommended based on evidence from the United States, Canada, and Australia that the higher age requirement for legal drinking is effective in decreasing alcohol-related crashes and associated injuries among 18- to 20-year-old drivers. Other potential benefits include decreased alcohol consumption. No harms were reported and no qualifying economic information was identified from the literature.

Sobriety Checkpoints: Strongly Recommended.

Sobriety checkpoints are designed to systematically stop drivers to assess their level of alcohol impairment. The goal is to deter alcohol-impaired driving by increasing the perceived risk of arrest. There are two types of sobriety checkpoints. At random breath testing (RBT) checkpoints, all drivers are stopped and tested for blood alcohol levels. Random breath testing checkpoints are common in Australia and several European countries. In the United States, selective breath testing (SBT) checkpoints are used. At these checkpoints, police must have a reason to suspect that the driver has been drinking (i.e., probable cause) before testing blood alcohol levels. Sobriety checkpoints are strongly recommended based on their effectiveness in reducing alcohol-impaired driving, alcohol-related crashes, and associated fatal and nonfatal injuries in a variety of settings and among various populations. Corollary arrests are a potential added benefit. The brief intrusion this entails into drivers´ privacy is generally considered justified by the public interest served by checkpoints. Four economic studies were identified, all of which indicated sizeable economic benefits.

Intervention Training Programs for Servers of Alcoholic Beverages: Recommended, when conducted as high quality face-to-face training,

accompanied by strong management support. There is insufficient evidence of the effectiveness of community-wide programs.

Server intervention training programs provide education and training to servers of alcoholic beverages with the goal of altering their serving practices to prevent patron intoxication and alcohol-impaired driving. These practices can include offering food with drinks, delaying service to rapid drinkers, refusing service to intoxicated patrons, and discouraging intoxicated patrons from driving.

Server intervention training programs are recommended on the basis of evidence that high quality face-to-face training, when accompanied by strong management support, is effective in reducing the level of intoxication among patrons. The evidence on which this recommendation is based comes primarily from small-scale studies in which the participants may have been unusually motivated and the researchers had a high degree of control over the implementation of the server training. Although these findings are promising, they may not apply to larger, community-wide server training programs for which evidence is insufficient. No qualifying economic information was identified for either type of program.

Definitions:

Strength of Evidence of Effectiveness = Strength of Recommendation

In general, strength of evidence of effectiveness links directly to strength of recommendation as follows:

- Strong: Strongly recommended
- Sufficient: Recommended
- Insufficient: Available studies do not provide sufficient evidence to determine effectiveness
- Sufficient or strong evidence of ineffectiveness or harm: Recommend against

### CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The recommendations are based on 175 qualifying studies, all of which had good or fair execution quality. In general, the strength of evidence of effectiveness corresponds directly to the strength of recommendations (see the "Major Recommendations" field). Detailed descriptions of the evidence are provided in the companion documents to the guideline (see the "Companion Documents" field).

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

Decreased risk of injury or death from motor vehicle crashes.

Subgroups Most Likely to Benefit:

Children and young adults are most likely to benefit, since motor vehicle-related injuries kill more children and young adults than any other single cause in the United States.

### POTENTIAL HARMS

A potential harm of safety belt laws and primary enforcement of these laws can be found in the theory that safety belt use will lead to other unsafe driving behaviors, thus neutralizing any beneficial effect that their use might confer. No studies reviewed, however, have shown an association between safety belt laws and increases in unsafe driving behaviors. In addition, although differential enforcement based on race or ethnicity has been reported as a concern, studies that looked for evidence of such differential enforcement found none.

A potential harmful effect of laws establishing a lower legal blood alcohol concentration (BAC) for young or inexperienced drivers is that young drivers whose BACs exceed the legal limit for adult drivers (0.08 g/dL or 0.10 g/dL) may receive "zero tolerance" citations instead of being arrested for the more serious offense of driving under the influence of alcohol.

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

- These guidelines should not be viewed as the sole source for informed public health decision making because local contextual information is also important. Many issues not addressed in these guidelines will affect which interventions are implemented (e.g., resource availability, social justice, community participation, cultural appropriateness, local burden of diseases and risk factors, and political considerations). However, these guidelines provide systematically collected and detailed information on several issues of importance to public health practitioners and decision makers; information which is difficult or inefficient to develop locally. Guideline reviews and recommendations will be most useful in conjunction with a participatory community planning process that clarifies needs and goals and that considers the guideline´s evidence reviews and recommendations in conjunction with additional applicable community-specific information.
- A clear gap in the Task Force on Community Preventive Services' recommendations is for children who are too old or too large to sit in child safety seats but who are too small to wear safety belts without the use of booster seats (generally children aged 4 to 8 years). The literature base regarding the efficacy of booster seats, and particularly that of population-based interventions to improve their use, is still emerging.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

- Given that motor vehicle occupant injuries are the leading cause of injury death among people aged 1 to 34 in the United States, reducing the number of motor vehicle crashes and crash-related occupant injuries should be relevant to most communities. States and communities can compare their current motor vehicle injury prevention interventions and activities with recommendations in the guideline. They can then take steps to ensure that existing interventions are adequately implemented and funded, while considering implementation of other recommended interventions.
- The Task Force on Community Preventive Services recommendations can be used to support or expand child safety seat distribution programs, bolster the use of incentives, and employ enhanced enforcement campaigns, all in conjunction with community-wide education efforts.
- The Task Force on Community Preventive Services recommendations can be also used to promote the adoption, maintenance, or strengthening of state or national laws or regulations.

The reader is directed to the original guideline and companion documents for additional information on implementation and barriers to implementation of these recommendations.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Staying Healthy

### IOM DOMAIN

Effectiveness
Safety

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Recommendations to reduce injuries to motor vehicle occupants: increasing child safety seat use, increasing safety belt use, and reducing alcohol-impaired driving. Am J Prev Med 2001 Nov;21(4 Suppl 1):16-22. [35 references]

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

### DATE RELEASED

2001 Nov

## GUIDELINE DEVELOPER(S)

Task Force on Community Preventive Services - Independent Expert Panel

## SOURCE(S) OF FUNDING

United States Government

## GUIDELINE COMMITTEE

Task Force on Community Preventive Services

## COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Task Force on Community Preventive Services Members: Fielding, Jonathan, M.D., M.P.H., M.B.A. (Chairperson); Mullen, Patricia Dolan, Dr. P.H. (Vice Chairperson); Brownson, Ross, Ph.D.; Fullilove, Mindy, M.D.; Guerra, Fernando, M.D., M.P.H.; Hinman, Alan R., M.D., M.P.H; Isham, George J., M.D.; Land, Garland H., M.P.H.; Mahan, Charles S., M.D.; Nolan, Patricia A., M.D., M.P.H.; Scrimshaw, Susan C., Ph.D.; Teutsch, Steven M., M.D., M.P.H.; Thompson, Robert S. (Tommy), M.D.

Consultants: Lawrence, Robert S., M.D.; McGinnis, J. Michael, M.D.; Novick, Lloyd F., M.D., M.P.H.

## FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

## GUIDELINE STATUS

This is the current release of the guideline.

This guideline is subject to periodic updates.

## GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Task Force on Community Preventive Services Web site. Also available from the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Web site.

Print copies: Available from the Community Guide Branch, Epidemiology Program Office, Centers for Disease Control and Prevention, 4770 Buford Highway, Mailstop K-73, Atlanta, GA 30341.

## AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Guideline Summary:

- Motor-vehicle occupant injury: strategies for increasing use of child safety seats, increasing use of safety belts, and reducing alcohol-impaired driving. A report on recommendations of the Task Force on Community Preventive Services. MMWR Recomm Rep 2001 May 18;50(RR07);1-13. Available from the Centers for Disease Control and Prevention (CDC) Web site: Portable Document Format (PDF) File; HTML File

Evidence Reviews:

- Zaza S, Sleet DA, Thompson RS, Sosin DM, Bolen JC, Task Force on Community Preventive Services. Reviews of evidence regarding interventions to increase use of child safety seats. Am J Prev Med 2001 Nov;21(4 Suppl):31-47.
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Guideline-Specific Background Articles:

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General Background Articles:

- Truman BI, Smith-Akin CK, Hinman AR, Gebbie KM, Brownson R, Novick LF, Lawrence RS, Pappaioanou M, Fielding J, Evans CA, Jr., Guerra F, Vogel-Taylor M, Mahan CS, Fullilove M, Zaza S, Task Force on Community Preventive Services. Developing the Guide to Community Preventive Services—overview and rationale. Am J Prev Med 2000 Jan;18(1 Suppl):18-26.

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- Zaza S, Wright-de Aguero L, Briss PA, Truman BI, Hopkins DP, Hennessy MH, Sosin DM, Anderson L, Carande-Kulis VG, Teutsch SM, Pappaioanou M, Task Force on Community Preventive Services. Data collection instrument and procedure for systematic reviews in the Guide to Community Preventive Services. Am J Prev Med 2000 Jan:18(1 Suppl):44-74.
- Carande-Kulis VG, Maciosek MV, Briss PA, Teutsch SM, Zaza S, Truman BI, Messonier ML, Pappaioanou M, Harris.J.R., Fielding J, Task Force on Community Preventive Services. Methods for systematic reviews of economic evaluations for the Guide to Community Preventive Services. Am J Prev Med 2000 Jan;18(1 Suppl):75-91.
- Zaza S , Pickett JD. The Guide to Community Preventive Services: update on development and dissemination activities. J Public Health Manag Pract 2001 Jan;7(1):92-4.
- Novick LF, Kelter A. The Guide to Community Preventive Services: a public health imperative. Am J Prev Med. 2001 Nov;21(4 Suppl):13-5.


Users can access the complete collection of companion documents at the Task Force on Community Preventive Services Web site.

Print copies: Available from the Community Guide Branch, Epidemiology Program Office, Centers for Disease Control and Prevention, 4770 Buford Highway, Mailstop K-73, Atlanta, GA 30341.

## PATIENT RESOURCES

None available

## NGC STATUS

This summary was completed by ECRI on May 6, 2002. The information was verified by the guideline developer on May 14, 2002.

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